

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/04/2015
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00165599, IN00167829 and IN00168144.</p> <p>Complaint IN00165599 - Substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00167829 - Substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00168144 - Substantiated, no deficiencies related to the allegations are cited.</p> <p>Survey dates: March 2, 3 and 4, 2015</p> <p>Facility number: 000220 Provider number: 155327 AIM number: 100267650</p> <p>Survey team: Diana Zgonc, RN-TC</p> <p>Census bed type: SNF: 35 SNF/NF: 114 Total: 149</p> <p>Census payor type: Medicare: 23 Medicaid: 96 Other: 30 Total: 149</p> <p>Sample: 7</p> <p>University Heights Health and Living Community was found to be in compliance with 42 CFR Part</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00165599, IN00167829 and IN00168144. Quality Review 03/05/15 by Lisa McColly	F 000			